Lessons From the Practice

Treachery of the Hysterical Diagnosis

LARRY E. DAVIS, MD, *Albuquerque, New Mexico*

Chief residency is the culmination of physicians' training—when they are finally able to make decisions with authority and confidence. And then patients come along, bringing with them lessons in humility.

Helen was a retired psychiatric nurse who arrived one evening in the emergency department saying that she could not move her legs. She was calm as she explained that the painless paralysis developed while she was watching a news story on Governor George Wallace, who had become paraplegic after being shot in the back. Discovering she could not walk, she somehow was able to go to bed that night and arrived at the emergency department the next day with a neatly packed suitcase. On examination she had normal muscle tone in the legs, but with effort she could barely lift her feet off the bed. All her test results were normal.

Nurses on her former psychiatry ward told me she had always been slightly eccentric. The psychiatry chief resident and I concluded she was hysterical, and we joked about calling her illness "Wallace hysterical paraplegia" or even "the Wallace syndrome." When we announced she could get up, go home, and start psychiatric counseling in the morning, she would not move. An hour passed. I was left with no choice but to call the medical intern and have her admitted to the hospital. Confidently I told the intern my diagnosis and went home.

Early the next morning I awoke with an inexplicable feeling that something about my diagnosis was amiss, and I quickly walked to the hospital. Helen politely wondered why I had awakened her so early as she still felt the same. Now, however, her legs were paralyzed, flaccid, and lacked deep tendon reflexes. My previous confidence turned to anxiety as I called a radiology colleague to do an emergency myelogram.

During a lull in the myelogram, I reviewed her initial laboratory findings. A pit formed in my stomach on finding that her electrocardiogram contained the configuration of an acute myocardial infarction. After the myelogram was completed, we headed for the coronary care unit.

Helen's myocardial infarction resolved, but the associated anterior spinal artery occlusion left her permanently paraplegic. Her calm demeanor remained unchanged, and she left pleased with our care. Yet, I was not pleased and fully realized the treachery of the hysterical diagnosis. Carelessly made, it was—and usually is—wrong. I had been so pleased with my diagnosis and its association with the George Wallace tragedy that I had failed to examine her admission electrocardiogram carefully. In addition, I learned how important it is to listen to patients and to clarify and understand their responses. On more careful questioning, Helen explained how she had crawled from the chair to the bed, how she avoided fluids because she knew she would not be able to get to the bathroom, and how a neighbor helped pack her suitcase and carried her to a waiting taxi. She had previously cared for paraplegics, knew what to expect, and was not scared.

Since then, whenever I encounter a weird or apparently implausible history, I remember Helen and ask careful questions, listen to the answers, and search for a possible "organic" explanation.

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"Lessons From the Practice" presents a personal experience of practicing physicians, residents, and medical students that made a lasting impression on the author. These pieces will speak to the art of medicine and to the primary goals of medical practice—to heal and to care for others. Physicians interested in contributing to the series are encouraged to submit their "lessons" to the series' editors.

JONATHAN E. RODNICK, MD
STEPHEN J. McPHEE, MD
Assistant Editors

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From the Neurology Service, Department of Veterans Affairs Medical Center, and the Departments of Neurology and Microbiology, University of New Mexico School of Medicine, Albuquerque, New Mexico.

Reprint requests to Larry E. Davis, MD, Neurology Service, VA Medical Center, 2100 Ridgecrest Dr SE, Albuquerque, NM 87108.